Testimony of
Mary M. Jagim, RN, BSN, CEN, FAEN

2001 President

Emergency Nurses Association

to the

Subcommittee on Emergency Preparedness, Science, and Technology

Committee on Homeland Security

United States House of Representatives

on

Emergency Care Crisis: A Nation Unprepared for Public Health Disasters

July 26, 2006

Good morning, Mr. Chairman and members of the Subcommittee. Thank you for convening this hearing to examine the current condition of emergency care and its implications for maintaining security in our nation. Characterized as "overburdened, short of resources, under funded, and fragmented", the present situation is an environment where emergency departments are less able to serve as the country's safety net in ordinary situations, much less able to appropriately handle the extraordinary events of natural and man-made disasters.

I am Mary Jagim, the Internal Consultant for Emergency Preparedness and Pandemic Planning for MeritCare Health System in Fargo, North Dakota, and a member of the Institute of Medicine's (IOM) committee that oversaw the development of the report, **Future of Emergency Care in the United States Health Sys-tem**. I am here today representing the Emergency Nurses Association (ENA) where I have served on the Board of Directors and as the 2001 President. ENA is the only professional nursing organization dedicated to defining the future of emergency nursing and emergency care through expertise, innovation, and leadership. It serves as the voice of more than 30,000 members and their patients through research, publications, professional development, injury prevention, and patient education. Recognized as an authority in the discipline of emergency care and its practice, ENA was invited by the IOM to share its data and expertise on the current state of U.S. emergency departments (EDs). On behalf of the Emergency Nurses Association, I appreciate this opportunity to discuss with the Subcommittee our particular concerns regarding hospital surge and mass trauma care capacity.

MASS TRAUMA AND EMERGENCY NURSING CARE

Emergency nurses are no strangers to mass casualty challenges. We engage continually in every aspect of patient care throughout the emergency care system. Emergency nurses conduct triage, the first application of medical care in the ED, assessing patient conditions and swiftly prioritizing needs within a rapidly changing scenario. We coordinate treatment and autonomously intervene at a moment's notice. In addition, it is our role to invest quality time with patients and their families as we teach them how to manage their conditions and prevent injuries. Emergency nurses are a critical member of daily emergency care and, owing to our requisite knowledge and skills, we occupy a unique role on the team of professionals delivering mass casualty care.

All hospitals and medical facilities across our country are vulnerable to mass casualty incidents. A mass casualty incident occurs as a result of an event where sudden and high patient volume exceeds an ED's resources. Such events may include the more commonly realized multi-car pile-ups, train crashes, hazardous material exposures in a building or across a community, high occupancy structural fires, or the extraordinary events such as pandemics, weather-related disasters, and intentional catastrophic acts of violence. In all cases and degrees of calamity, the emergency department is the entry point into the hospital system and is the initial facility-based, patient-care area for victims of a mass casualty incident.

FRAGMENTATION/REGIONALIZATION

ENA supports the IOM's assertion that the U.S. emergency care system needs to be coordinated and regionalized. The IOM report acknowledges that the nation's emergency care system is poorly prepared to care for ill and wounded patients following a mass casualty incident. It describes today's emergency care system as saturated, highly fragmented, and variable. In its 2002 **Mass Casualty Incidents** position statement, ENA recommended that emergency services be seamless with 911 and dispatch, ambulances, emergency medical services (EMS) personnel, hospital EDs, and trauma centers and specialists working in a coordinated manner. The ENA believes emergency care also must be regionalized to help ensure the patient is transported to the right hospital at the right time for the right care.

ENA supports the immediate reinstatement of funding for the HRSA Trauma-EMS Program in order to renew the work in the states toward establishment of state-wide trauma systems. The Trauma-EMS Program, administered by the Health Resources and Services Administration (HRSA), provided states with grants for planning, developing, and implementing statewide trauma care systems. Although only eight states have fully developed trauma systems, these statewide healthcare systems could be used as models for full regionalization of care. ENA recognizes the necessity of the Trauma-EMS Program, which has been the only federal source available to build a trauma system infrastructure in the United States. When it existed, the Trauma-EMS Program, which lost its funding in FY 2006, provided critical national leadership, and leveraged additional scarce state dollars, to optimize trauma care through system integration that offered seriously injured individuals, wherever they lived, prompt emergency transport to the nearest appropriate trauma center within the "golden hour." The IOM report bolsters support for such regionalized models of care by drawing on substantial evidence that "demonstrates that doing so [i.e., creating a coordinated, regionalized system] improves outcomes and reduces costs across a range of high-risk conditions and procedures."

ENA supports the IOM's call for a series of research demonstration projects that will put these ideas into practice by testing these strategies under various emergency care conditions. Achieving this result takes coordination, commitment of staff, development and implementation of standards of care, a process for designating trauma centers, and evaluation. To this end, ENA has advocated a regionalization that gathers together all community stakeholders to examine all alternatives for providing appropriate patient care and better patient outcomes. Our organization supports a best practice of coordinated, community-wide response planning, using a common framework that is applicable to all hazards and that links local, state, regional, and national resources.

DISASTER PREPAREDNESS

ENA supports development of basic and advanced continuing-education courses and training to prepare emergency nurses in the care and treatment of victims, across all age groups and diverse populations, of mass casualty incidents. Disaster preparedness is an essential function of frontline emergency nurses and the emergency care continuum. Emergency preparedness for mass casualty incidents should be a major part of an emergency nurse's training and should be reflected in the work she or he does every day. Our organization, through its conferences and publications, including the quarterly **Disaster Management and Response** journal, provides its members with information and resources on disaster preparedness. But as the IOM report points out, in general, a lack of planning, training, and supplies, along with limited federal funding, complicates the mass casualty readiness situation at the hospital ED level across the country.

ENA joins the IOM in urging an increase in federal funding allocated to assist hospitals in plan-ning, in training, and in equipment and supply procurement for all-hazards disaster prepared-ness. Although EDs play a significant role in the medical response to major disaster events, a current imbalance exists in funding allocations. Funding either has not reached all hospitals, or – for those that received funding – the average amount was between $5,000 and $10,000 in 2002 and 2003. Owing to the capacity needs and infrastructure that must be advanced to meet the national goal of an emergency care system ready to appropriately respond to all-hazards disasters, the allocation of federal emergency preparedness funds is grossly insufficient.

For example, a considerable amount of the federal funding has been allocated to fire. Much of this funding has been used for equipment procurement and training involving chemical and biological contamination. Past experience has shown that in disasters of mass contamination, only a portion – as little as 20 percent – of the victims remain on scene for decontamination and medical care. The remaining 80 percent present at the hospital ED, where the appropriate equipment and training have been under funded, if funded at all. The fire and EMS personnel and equipment at the disaster scene are not available to respond and assist with the decontamination needs of the majority of the victims who are presenting to the ED. The allocation of emergency preparedness monies to hospitals has been disproportionate to the share of the medical response to major disaster events delivered by EDs. Without specific funding provided to hospitals for the purposes of planning, training, and procurement, these activities will not occur, leaving hospitals under- or unprepared, and our national goal of disaster preparedness unmet.

The ENA unites with COMCARE, a nonprofit national advocacy organization dedicated to ad-vancing emergency communications, in advocating that emergency communications systems and "interoperability" are defined to include interorganizational data communications and data communications generally. Coordinated and comprehensive communication is another critical aspect of disaster preparedness for mass casualty events. Appropriate protection of the public requires continuous, redundant, and reliable systems of all forms of communications and information technology. As a member of COMCARE, ENA recognizes the vital nature of data and information technology, whether supporting emergency alerts to agencies and the public, shared

systems for incident management and situational awareness, patient tracking applications, resource management, or scores of other uses. Fully interoperable parameters necessitate the use of integrated, multimode emergency communications systems designed to communicate with one another on demand in real time, and – as necessary – support voice and data interchange between the emergency and emergency support organizations, in addition to radio communications with mobile staff.

ED nurses, along with all other medical and emergency responders, need to be able to receive, send, and access all kinds of patient data on a daily basis. An example is the frequent occurrences of patients arriving at the ED on their own, by ambulance, or as a result of an evacuation from another hospital without any information regarding their medical history. Healthcare workers should have access to all of the appropriate information: Who is the primary physician? What medicines is the patient taking? What are the vitals? What treatments have already been given? Our members need to communicate and share information with other professions and jurisdictions so that we can provide the best care possible to our patients during and after everyday emergencies and mass casualty disasters.

ENA supports COMCARE in recommending that the local, regional, and state emergency com-munications planning and implementation required by current federal guidelines be conducted as an integrated whole, including all organizations involved with emergency response, and all forms of communications. We are concerned that the current planning processes are focused too narrowly and are compromising our nation's ability to rapidly improve our response capabilities. All organizations involved in emergency preparation and responses need to participate in planning and deployment. Furthermore, not only must funding guidelines allow expenditures on software and emergency services information technology in addition to equipment procurement, but the guidelines also must provide for planning and training.

THE FOUNDATION OF THE EMERGENCY CARE SYSTEM

Preparing for hospital surge and mass trauma care capacity will not happen without remediation of the general emergency care system infrastructure.

NURSING WORKFORCE AND NURSING FACULTY SHORTAGES

The IOM report also notes that nursing shortages in U.S. hospitals continue to disrupt hospital operations and are detrimental to patient care and safety. Because of the unique insight and clinical knowledge of an experienced emergency nurse, the nursing shortfalls constitute a loss of expertise in the system. Nurses are not interchangeable resources. The expertise of a seasoned ED nurse is critical to achieve quality patient outcomes in a dynamic healthcare system that demands competencies for a multitude of situations, including all-hazards mass casualty events. Hospital staffing systems must acknowledge the need for, and incorporate, training and education time and funding for emergency nurses.

ENA agrees with the IOM's recommendation that federal agencies must jointly undertake a detailed assessment of emergency and trauma workforce capacity, trends, and future needs to develop strategies meeting these needs in the future. Today's nursing shortage is very real and very different from any experienced in the past. The existing shortage is evidenced by an aging workforce and too few individuals entering the profession. A critical factor exacerbating the national nurse-workforce deficiency is the declining number of qualified nurses available to teach future generations of registered nurses.

ENA supports the IOM's assertion that national standards for core competencies applicable to nurses and other key emergency and trauma professionals be developed using a national, evidence-based, multidisciplinary process. To date, the ENA-affiliated Board of Certification of Emergency Nursing (BCEN®) has credentialed 14,000 Certified Emergency Nurses (CEN®) and more than 1,000 Flight Registered Nurses (CFRN®). BCEN® also recently announced the launch of the Certified Transport Registered Nurse (CTRN™) certification for nurses qualified to move patients between medical facilities.

The ENA is on record advocating increased federal efforts to support:

- Effective strategies for the recruitment, retention, and continuing education of registered nurses working in emergency departments, providing safe, efficient, quality care, especially during crisis situations when the ED is crowded and functioning above capacity; and

- New strategies to increase the numbers of individuals pursuing nursing careers, as well as initiatives to increase qualified nursing faculty, who are vital to addressing the nursing shortage.

CROWDING

Crowding in our nation's emergency departments is of increasing concern. In our 2005 position statement **Crowding in the Emergency Department**, ED crowding is described as "a situation in which the identified need for emergency services outstrips available resources in the emergency department. This situation occurs in hospital emergency departments when there are more patients than staffed ED treatment beds and wait times exceed a reasonable period."

When crowding occurs, patients are often placed in hallways and other nontreatment areas to be monitored until ED treatment beds or staffed hospital inpatient beds become available. In addition, crowding may contribute to an inability to triage and treat patients in a timely manner, as well as increased rates of patients leaving the ED without being seen. As a result of crowding, hospitals often implement ambulance diversion measures.

An emergency care system that is beyond saturation on a daily basis will have limited ability to respond to the surge of patients related to catastrophic events. The federal government must

establish clear leadership and directed funding support to coordinate the functions of emergency care, as well as assist in providing system incentives for nonemergency care that is delivered in areas outside of the ED.

One aspect of crowding that ENA continues to address concerns the interpretation of emergency care's federally mandated regulations. ENA wholeheartedly endorses unencumbered access to quality emergency care by all individuals regardless of their financial status. However, EMTALA, the **Emergency Medical Treatment and Labor Act** which ensures public access to emergency services regardless of ability to pay, has had the unintentional effect of increasing unnecessary visits to the ED for acute and chronic conditions that do not meet the Centers for Medicare and Medicaid Services' (CMS) definition of "emergency medical condition".

ENA acknowledges an attempt by CMS to lessen the restrictions regarding patients with nonemergent conditions. Despite a CMS clarification, much confusion continues to surround this issue, grounded in fear of possible reprisals for failure to strictly adhere to EMTALA mandates. EMTALA continues to limit an ED's options to manage its patient load by limiting its ability to send nonurgent patients off-site for clinical care, rather than conducting a full medical assessment in the ED. Nurses cannot tell a patient probable wait times or suggest alternatives for care under the current rules. With severe crowding and ambulance diversions identified as a national crisis, compounded by the increase in patients using the ED for primary care, some flexibility is needed for clinical judgment by an ED practitioner (who has experienced an actual encounter with the patient) to identify those patients who do not obviously meet the definition of an emergency medical condition.

Notwithstanding EMTALA regulations, the problem of crowding is not confined to the ED, and is considered a systems issue, which can be examined at department and institution levels as well as at local, regional, and national levels. The factors contributing to ED crowding are numerous and varied and have been well documented in the literature. The root causes of ED crowding are embedded in the crisis of health care in the U.S., requiring solutions that may fall outside of the ED's control. The ENA believes crowding is caused by

- Hospital/trauma center closures;
- Lack of inpatient beds, forcing emergency departments to hold patients;
- Increased use of emergency departments over the past decade; and
- Lack of universal access to primary and preventative health care and the use of the emergency department for primary care.

To address crowding, ENA recommends increased federal funding to support:

- Collaborative research by emergency nurses and physicians to develop and implement new flow management solutions for the emergency department to both prevent and manage ED crowding;

Professional and public awareness programs as well as legislative efforts to reduce visits to the ED by
(1) strengthening capacity for nonemergent care by increasing access to primary care providers in the community and teaching when and how to access emergency care; (2) reducing the numbers of uninsured and underinsured; (3) reducing trauma caused by preventable injuries, violence, and substance abuse; and (4) improving prevention, wellness, and disease management efforts; and

Evaluation and prioritized performance incentives that increase capacity and efficiency, not only in the emergency department, but within hospitals and other patient care facilities in order to help reduce the burdens suffered by ED patients when emergency departments become too crowded for patients needing specialized care.

STATUTORY NATURE OF U.S. EMERGENCY CARE

When the American public is asked about its views on trauma centers and trauma systems, large majorities value them as highly as having a police or fire department in their community. In addressing the crucial nature of regionalized trauma services, the IOM report notes that trauma care "is widely viewed as an essential public service." The report further states that "unlike other such services [e.g., electricity, highways, airports, and telephone service . . . created and then actively maintained through major national infrastructure investments] access to timely and high quality . . . trauma care has largely been relegated to local and state initiative".

The dilemma of emergency care with readiness for mass casualty events runs deeper than the disparity between the perceptions of emergency care as a public service and the funding underlying the system. A distinctive policy characteristic of emergency care is that emergency care is legislated (e.g., as previously suggested in the EMTALA regulations discussion). Of all the health care disciplines, emergency care is the one that is mandated by the United States government. In effect, the government has promised the people that emergency care will be a service to which the public has a lawful right (not just a discretionary, moral right). This statutory nature holds special implications, evoking general questions such as:

How does federal support of this public service compare to support of other legislated services?; and

To what degree is the government legally accountable for delivery of this right/public service?

For emergency care nurses, this legal requirement reinforces respective professional duties and ethical commitments. As front-line providers of emergency care, ENA believes it is essential that every person in our country has access to a system that provides definitive care as quickly as

possible. The Emergency Nurses Association pledges our efforts and our expertise to work with you and your colleagues to assure the population's protection and well-being as homeland security compels.